Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
RUBEENA KHAN, DC

Respondent Name
TASB RISK MGMT FUND

MFDR Tracking Number
M4-14-1831-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
FEBRUARY 21, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Designated Doctor Examinations are billed according to DWC Rule 134.204 and in accordance with Labor Code 408.004, 408.0041, and 408.151."

Amount in Dispute: $550.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dr. Khan submitted a medical bill on 6/13/13 for date of service 5/16/13 with CPT code 99456 W5 & WP modifiers in the amount of $650.00.

- The Fund paid the total billed charges of $650.00 on 7/10/13 as follows: 99456 W5 (MMI portion) at $350.00 and $300.00 for range of motion of the lower extremity per rule 134.203(I and j).

Dr. Khan submitted another medical bill with the same charges as stated above on 10/9/13. We processed and appropriately denied as a duplicate on 10/24/13. This bill was not identified as a reconsideration.

Dr. Khan submitted a reconsideration with the exact same CPT codes ad charges as indicated above on 1/16/14. It was processed on 2/5/14 and no additional reimbursement was made.

Dr. Khan did not and has not billed us for what appears to be his current request for additional reimbursement of $550.00. They have not produced a HCFA 1500 claim form indicating this billing. His current request is only noted on the Medical Dispute form for with an additional 99456 for $500 and an additional 99456 for $50.00."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 16, 2013	CPT Code 99456 Designated Doctor Evaluation	$50.00	$0.00
	CPT Code 99456 Designated Doctor Evaluation	$500.00	$0.00
TOTAL		$550.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §133.250, effective July 1, 2012 requires healthcare providers to submit the medical bill for reconsideration prior to seeking medical dispute resolution.
4. Neither party to this dispute submitted copies of the explanation of benefits to support denial/reduction of payment for the disputed services.

Issues

1. Was the disputed filed in the form and manner required by 28 Texas Administrative Code §133.307?
2. Does the submitted documentation support that the disputed services are eligible for dispute resolution?

Findings

1. According to the submitted medical bill the requestor billed CPT code 99456-W5-WP for $650.00. Based upon the submitted explanation of benefits, the respondent paid $650.00 for CPT code 99456-W5-WP.

   28 Texas Administrative Code §133.307(c)(2)(J), requires that the request shall include "a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier . . . and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250" Review of the submitted documentation finds that the requestor has not provided a copy of the medical bill(s) as originally submitted to the insurance carrier and/or as submitted to the insurance carrier for an appeal in accordance with §133.250 for code 99456 at $50.00 and $500.00. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(J).

   28 Texas Administrative Code §133.307(c)(2)(K), requires that the request shall include "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider . . . or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB" Review of the submitted documentation finds that the request does not include [copies of any EOBs for the disputed services. Nor has the requestor provided evidence of insurance carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(K).

   The Division concludes that the dispute was not filed in the form and manner required by 28 Texas Administrative Code §133.307.
2. 28 Texas Administrative Code §133.250(i) states "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills)." As stated above, the requestor has not supported that the disputed services were submitted to the respondent prior to seeking medical dispute resolution. As a result, the disputed services are not eligible for medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		11/19/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.